Program Requirements and Application Process
Low Income Health Program (LIHP)

General Information

This document and information referenced in this document provide the program requirements for implementation of a Low Income Health Program (LIHP) by governmental entities. This document also indicates the process, method, and instructions for completing and submitting an application for requesting federal funding for the purposes of implementing the LIHP.

The LIHP consists of the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI) programs. These programs provide health care benefits to eligible persons in accordance with the Welfare and Institutions Code Section 15909 – 15915 (Chapter 723, Statutes of 2010, Assembly Bill 342), and the Special Terms and Conditions (STCs) of the federal section 1115(a) California Bridge to Reform Demonstration (Demonstration). Federal funding is available under the Demonstration for the health care benefits and allowable administrative activities costs associated with the program. The cost-claiming and reimbursement methodologies used to claim the federal funding for the health care benefits and administrative activities provided under the LIHP must be in compliance with the Centers for Medicare & Medicaid Services (CMS) rules and policies governing such claims.

The non-federal share of the federal reimbursement under the LIHP must be provided by the governmental entity authorized to implement the program. Implementation of the LIHP is subject to the availability of local non-federal funds. There will be no State General Fund monies allocated to the governmental entities for the program.

Definitions

For the purpose of this application the following definitions shall apply:

1. “Allocation” means the identification of the Health Care Coverage Initiative (HCCI) portion of the available federal funding for the approved applicants. The “allocation” will be the maximum level of Safety Net Care Pool (SNCP) funding available for the authorized applicant during the program year. “Allocation” does not mean a grant or a payment from the State.

2. “Applicant” means a governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority that applies for LIHP funds. Only these entities may apply to implement a LIHP.

3. “Approved Applicant” means an applicant who has met the requirements for

application approval specified in this application and whose application has been approved to participate in LIHP.

4. “Authorized Applicant” means the approved applicant is in compliance with the requirements to implement the LIHP and has been authorized to implement the LIHP.

5. “Certified Public Expenditures (CPEs)” means expenditures that a governmental entity certifies it has incurred in furnishing health care services to eligible enrollees, which are used as a mechanism for providing the non-federal share of the allowable federal payment under LIHP.

6. “Closed Network” means the specific health care providers that are authorized by LIHP to provide health care services offered to enrollees in the LIHP.

7. “Demonstration” means California's five year, “Bridge to Reform Section 1115(a) Medicaid Demonstration”, which permits deviation from the approved State Medicaid plan and authorizes program changes to implement the State transition to the federal health care reforms that will take effect in January 2014, related in particular to Medi-Cal program expansion.

8. “Eligible person” means a person who is to be served by the LIHP funded under the Demonstration who is between the ages of 19-64, non-pregnant, with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL), and at the time eligibility is determined, is not eligible for the Medi-Cal program or Children’s Health Insurance Program (CHIP), meets the citizenship and county of residency requirements, and if the family income falls between 133 and 200 percent of the FPL, and is uninsured. Only these eligible individuals may be enrolled in a MCE or HCCI under the LIHP.

9. “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    - Placing the health of the individual in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.

10. “Emergency Services” means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX, and needed to evaluate or stabilize an emergency medical condition.

11. “Federally Qualified Health Center (FQHC)” means an entity receiving a grant under Section 330 of the Public Health Service (PHS) Act; or receiving funding from such a grant under a contract with the recipient of a Section 330 grant, and meet the requirement to receive a grant under Section 330 of the PHS Act; or is an FQHC “Look-Alike,” not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services (HHS) to meet the requirements for receiving such a grant, even though it is not actually receiving such a grant; or was treated by Secretary of the Department of HHS for the purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1990; or is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or by as an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

12. “Health Authority” means a separate public agency established by the Board of Supervisors of a county (or city and county) pursuant to State law, and that has the authority and scope of services available to participate in the LIHP.

13. “Health Care Coverage Initiative (HCCI) Population”

    - Existing enrollees: Individuals between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL, and who were enrolled in the “Medi-Cal Hospital/Uninsured Care Demonstration” on November 1, 2010.

    - New enrollees: Individuals between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL and meet the income standards as established for each HCCI, are not eligible for Medicaid or CHIP, do not have third party coverage, and who were enrolled after November 1, 2011.

14. “Implementation Date” means the date the authorized applicants start their LIHP. The LIHP can not be implemented until the approved applicant is authorized and a contract with DHCS has been executed for LIHP. Authorized applicants without existing HCCI enrollees can not enroll eligible adults until the LIHP is implemented.

15. “Intergovernmental Transfer (IGT)” means the transfers of public funds from one level of government to another (such as from county to state government) to enable the funds to be used as the non-federal share for purposes of claiming federal Medicaid funds.

16. “Low Income Health Program (LIHP)” is a county-based elective program that consists of two components, the MCE and HCCI. MCE provides a broader range of medical assistance than the HCCI. MCE is subject to all applicable

Medicaid laws and regulations except as expressly waived or described in the STCs of the Demonstration. HCCI is subject to Medicaid laws or regulations except as specified in the expenditure authorities of the Demonstration.

17. "Managed Care Delivery System" means a county based delivery system with a closed network.

18. "Medical Home" means a single provider, facility, or health care team that maintains an enrollees' medical information, and coordinates health care services for enrolled individuals. The medical home shall provide, at a minimum, all the elements pursuant to Welfare & Institution Code (W&I Code) Section 15910.2(b)(2).

19. "Medicaid Coverage Expansion (MCE) Population":

    - Existing enrollees: Individuals between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Demonstration" on November 1, 2010.

    - New enrollees: Individuals between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL and meet the income standards as established for each MCE, are not eligible for Medicaid or CHIP, and who were enrolled after November 1, 2010.

20. "Post-Stabilization Care Services" means covered services related to an emergency medical condition that, subject to approved protocol established by the authorized applicant, are provided after an enrollee's condition is stabilized in order to maintain stabilization or to improve or resolve the enrollee's condition.

21. "Program Year" means each of the following periods:

    - Program Year One (November 1, 2010, through June 30, 2011).

    - Program Year Two (July 1, 2011, through June 30, 2012.)

    - Program Year Three (July 1, 2012, through June 30, 2013.)

    - Program Year Four (July 1, 2013, through December 31, 2013.)

22. "Safety Net Care Pool (SNCP)" means a federal funding limit set for claiming the allowable expenditures specified in the STCs of the Demonstration.

23. "Special Terms and Conditions (STCs)" means the document issued by CMS that (1) establishes the conditions and limitations on waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid

plan, and (2) describes in detail the nature, character, and extent of federal involvement in the Demonstration and the State's obligations to CMS. The STCs include the specific coverage categories, benefits, cost-sharing requirements, and financing mechanisms under which the Demonstration will operate.

24. "Total Funds Expenditures (TFEs) means the total allowable costs incurred by the authorized applicant for LIHP services provided to LIHP enrollees.

25. "Upper Income Limit" means the highest allowable income level for eligibility into the LIHP. The highest allowable family income for MCE is 133 percent of the FPL and 200 percent of the FPL for HCCI. The upper income limit may be reduced below these allowable amounts by the applicant.

LIHP Funding Amounts and Requirements

The MCE is not limited to a maximum level or subject to a cap on federal funding or a specified funding allocation. The authorized applicant's MCE federal reimbursement will only be limited by the amount of local non-federal funds the applicant voluntarily agrees to provide for MCE expenditures annually.

In contrast, under HCCI, there is a cap on federal funding and the approved applicants will receive allocations within the restricted amounts available for the program under the SNCP. Federal funds in the amount of $180,000,000 will be available for each of the first three consecutive program years to provide health care services for eligible HCCI enrollees. In program year four, ending December 31, 2013, federal funds in the amount of only $90,000,000 will be available for the HCCI.

Allocation Process and Requirements

DHCS will allocate available federal funds to be claimed under the SNCP for HCCI to applicants that are approved through the approval process. The HCCI allocations will include allocations for both existing and new HCCI enrollees. Approved applicants with existing HCCI enrollees will receive, at a minimum, an allocation adequate to ensure that existing HCCI enrollees can continue to receive services under the existing program from November 1, 2010, forward, even if they choose not to implement a new HCCI program. Those approved applicants with existing HCCI enrollees who choose to implement a new HCCI program will be allocated an amount above the minimum for new HCCI enrollees. Approved applicants without existing HCCI enrollees will only receive an allocation for new enrollees. DHCS shall base the determinations for annual allocations for the approved applicants on the amount of funding voluntarily provided for the non-federal share of the expenditures for health care services, the amount of funds requested to ensure that existing HCCI enrollees can continue to receive services, the total allocation requested for the program, and the total amount of funding requested by all applicants.

DHCS intends to allocate the HCCI funding to authorized applicants for the entire funding period, ending December 31, 2013. DHCS is not required to fund the entire amount requested in any one particular application, and may reduce requested allocations to fund additional applicants' programs. DHCS will open subsequent application periods for the following reasons:

- All California counties have not been authorized to implement a HCCI program,
- Prior applicant that was not approved in a prior application period,
- Authorized applicant that requests expansion of their HCCI program with an additional allocation,
- All available HCCI federal funds have not been allocated.

During subsequent application periods, counties may submit or resubmit withdrawn applications. Subsequent HCCI allocations to authorized applicants determined through this process will be based on the remaining available federal funds.

Allocations must be approved by CMS before DHCS can notify approved applicants of the allocation determinations. Approved applicant's income eligibility procedures, estimated upper income limits, enrollment projections, and TFEs must be submitted to CMS before the HCCI allocations can be approved.

Federal Reimbursement and Claiming Protocols for Health Care Services and Administrative Activities

Counties with existing HCCI enrollees may claim federal financial participation (FFP) for services provided to their enrollees from November 1, 2010 through July 1, 2011, according to the claiming protocols in Attachment G, Supplement 1, Cost Claiming Protocol for Reimbursement of Health Care Services Provided under the Health Care Coverage Initiative, under the California Medi-Cal Hospital/Uninsured Care Section 1115 Demonstration amended February 1, 2010, subject to the SNCP limits for qualifying expenditures for enrollees with family incomes from 0 to 200 percent of the FPL. DHCS will initiate an amendment to the contracts for the existing HCCI counties to operationalize this process.

Additionally, if these counties comply with the new MCE requirements by July 1, 2011, the expenditures, for those enrollees with family incomes at or below 133 percent of the FPL, can be claimed as MCE expenditures once new contracts with DHCS for the LIHP are executed; and claiming and reimbursement protocols for the MCE program have been approved by CMS.

Counties with existing HCCI enrollees that do not elect to participate in the MCE may claim federal reimbursement for the health care services expenditures for these enrollees against the amount of restricted HCCI funding allotted under the SNCP for those health care services expenditures from November 1, 2010 until the effective date of their decision not to implement the MCE and HCCI programs, but no later than July 1, 2011. The county can not enroll any new applicants after this effective date. However, these counties can continue to provide services to applicants enrolled up to this effective date and claim against the SNCP until December 31, 2013. These existing HCCI enrollees will receive the benefits and rights under the LIHP even though a LIHP program is not implemented.

Counties with existing HCCI enrollees that do not elect to participate in the HCCI may claim federal reimbursement for the health care services expenditures for these enrollees against the amount of restricted HCCI funding allotted under the SNCP for those health care services expenditures from November 1, 2010 until the effective date of their decision not to implement the new HCCI program, but no later than July 1, 2011. The county can not enroll any new applicants after this effective date. However, these counties can continue to provide services to applicants enrolled up to this effective date and claim against the SNCP until December 31, 2013. These existing HCCI enrollees with family incomes above 133 through 200 percent of the FPL, will receive the benefits and rights under the LIHP even though a new HCCI program is not implemented.

An authorized applicant without existing HCCI enrollees who has met all the LIHP requirements and has been authorized to implement a LIHP, may claim FFP for qualifying expenditures for their LIHP eligible enrollees, once a contract with DHCS has been executed and claiming and reimbursement protocols have been approved by CMS. These applicants will claim expenditures for MCE enrollees from uncapped federal funds and claim expenditures for HCCI enrollees for reimbursement of federal funds up to their HCCI allocation.

Reimbursement Mechanisms

The expenditures for health care services may be reimbursed through actuarially sound per capita rates, or through cost-based payments through mechanisms in accordance with the methodology approved for the Health Care Coverage Initiative programs under the previous section 1115 Medicaid Demonstration (Medi-Cal Hospital/Uninsured Care Demonstration). The non-federal share of the actuarially sound per capita rates may be provided by permissible ITGs or CPEs from the governmental entities. The use of CPEs as the non-federal share of the per capita rates is restricted to the CPEs incurred in payment of the rates to a third party contractor for providing LIHP health care services. The non-federal share of cost-based payments must be the CPEs from the governmental entities. The LIHP may elect to include as funding voluntary IGTs or CPEs of another governmental entity. The reimbursement mechanism may be changed from one program year to another.

DHCS must review and authorize the reimbursement mechanism selected by the authorized applicant. The reimbursement mechanisms for the program must be further reviewed and approved by CMS in the funding and reimbursement protocol for the LIHP as required by the STCs of the Demonstration.

Each authorized applicant that elects the CPE or the capitated rate mechanism with the non-federal share funded through CPEs, must certify its expenditures in accordance with federal guidance for the program as required for DHCS to claim the federal funds made available from the federal allotment. The CPEs reported to DHCS must reflect the TFEs for the services provided. Based on the CPEs reported by each authorized applicant, DHCS will claim FFP for reimbursement of the federal share of CPEs to the authorized applicants. The authorized applicants must incur the total amount of expenditures. The authorized applicant is responsible for expending 100 percent of the costs (TFEs) of providing health care services to LIHP enrollees using local funds prior to certifying its expenditures (CPEs) to DHCS for claiming federal reimbursement (its annual federal HCCI allocation). The authorized applicant may only certify expenditures to DHCS that it has actually made. CPEs may not be made on the basis of invoices or billings that have not been paid.

DHCS will claim FFP for the reimbursement of CPEs for the provision of health care services for LIHP enrollees. DHCS will reimburse the authorized applicant an amount equal to the FFP received by DHCS at the applicable Federal Medical Assistance Percentage (FMAP). Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50 to 61.59 percent from October 1, 2008, through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77 percent from January 1, 2011, through March 31, 2011, and 56.88 percent from April 1, 2011 through June 30, 2011. As of July 1, 2011, California's FMAP will be 50 percent. No State General Fund monies will be used to fund LIHP health or administrative costs incurred by authorized applicants.

Alternatively, each authorized applicant that elects to use IGTs on a quarterly basis shall transfer to DHCS the amount necessary to meet the non-federal share of estimated reimbursement to the LIHP for the next quarter. DHCS shall obtain the FFP to reimburse the governmental entity at the applicable FMAP as discussed above.

All local funds used as the non-federal share of LIHP expenditures must be public funds that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Section 1903(w) of the Social Security Act) and Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible IGTs from SNCP providers, or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

Maintenance of Effort (MOE)

In order to assure compliance with the MOE, authorized applicants that did not have a HCCI must expend non-federal funds for services to low-income individuals in the annual amount of no less than the amount expended by the applicant in State Fiscal Year 2010-11, in the absence of the Demonstration. This amount of expenditures is considered the MOE for the authorized applicant and must be maintained for each State Fiscal Year during which the authorized applicant's LIHP is in operation. Authorized applicants with existing HCCI enrollees, must meet this same requirement with the exception that the annual amount of expenditures must be no less than the amount expended by the applicant in State Fiscal Year 2006-07.

The MOE calculation is incorporated in the LIHP contract executed between DHCS and the authorized applicant. DHCS will provide further guidance on the MOE calculation and various expenditure exemptions allowable in the calculation prior to initiation of the contract process.

Administrative Cost Claiming

Federal funding is available for reimbursing authorized applicants for their allowable administrative activities costs incurred in their LIHPs. The administrative cost claiming method for the LIHPs will be determined through the negotiation and approval of a claiming protocol with CMS. The approved protocol will enable the authorized applicants to receive federal funding at a 50 percent reimbursement rate for the allowable administrative activities costs that comply with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." The protocol will describe the methodology that will be used to capture administrative costs associated with the LIHP, the requirements regarding documentation for compensation of salary and wages and acceptable mechanisms for allowing such costs. It will describe how other revenue sources will be offset for administrative expenditures associated with the LIHP, and detail the oversight and monitoring of administrative claiming.

DHCS anticipates that CMS will approve the administrative cost claiming protocol by July 1, 2011. DHCS recommends that eligible entities begin to document start-up administrative costs as soon as possible in order to have an auditable record of those costs for future claiming.

Eligibility and Enrollment Requirements

All LIHPs must develop standardized eligibility and enrollment procedures that comply with Medicaid . Additionally, LIHPs must develop eligibility income standards, methodologies and procedures for the MCE and HCCI populations that comply with the requirements of the California Code of Regulations, title 22, section 50501 et. seq.

Applicants will provide non-binding estimates of the number of enrollees by program year for MCE, HCCI, existing and new enrollees.

Enrollment is effective back to the first of the month in which the eligible applicant applied but no earlier than November 1, 2010. Additionally, retroactive eligibility may be extended up to three months prior to the date of application but no earlier than November 1, 2010.

MCE enrollees will be disenrolled in accordance with Medicaid law and policy; or if they no longer reside in the county participating in the MCE program.

HCCI enrollees will be disenrolled if they exceed income limits allowed for the program at redetermination; voluntarily withdraw from the program; no longer reside in the County participating in the HCCI; become incarcerated or are institutionalized in an Institute for Mental Disease (IMD); attain age 65; are no longer living; or obtain other health coverage.

Only the counties with existing HCCI programs may provide services to existing enrollees who were enrolled in HCCI on November 1, 2010. Initially all existing enrollees will be considered HCCI. Upon implementation of the MCE and the effective date of achievement of the new MCE requirements no later than July 1, 2011, the existing HCCI enrollees will be appropriately designated as either MCE or HCCI based on the following criteria:

- Existing MCE enrollees are those with family incomes at or below 133 percent of the FPL.

- Existing HCCI enrollees are those with family incomes above 133 through 200 percent of the FPL.

Allocations for expenditures for both existing and new HCCI enrollees will be determined by DHCS. Even if a HCCI program is not implemented, an allocation for existing HCCI enrollees will be determined to ensure the continued provision of services under the Demonstration.

The authorized applicants will develop standardized eligibility and enrollment procedures for MCE and HCCI that comply with the applicable Medicaid eligibility methodologies and procedures pursuant to the Code of Federal Regulations, Title 42 CFR Sections 431, 435, and 438 specifically

- Section 435.905 et seq. - application requirements

- Section 435.911 et seq. - timeliness requirements, notice and case documentation

- Section 435.916 et seq. - redetermination requirements

- Section 435.930 - continuous Medicaid
- Section 431.18 - provision and availability of program manuals/rules
- Section 431.200 et seq. - notice and rights to hearings
- Section 431.300 et seq. - information safeguarding
- Section 435.400 et seq. - general eligibility requirements
- Section 438.400 et seq. - internal grievance and appeal

Identity Verification

- Section 435.522 - age verification (under 64)
- Section 435.910 - Social Security Number verification
- Section 435.406 - citizenship verification
- Section 435.403 - residency verification
- Section 435.940 - Income and Eligibility Verification Requirements (IEVS)
    - Income verification, 42 CFR, Section 435.940 et seq.
    - Required to apply for and receive all unconditionally available income,
    - IEVS verification,

Any authorized applicant's eligibility procedures and methodologies which differ from Medicaid methodologies and procedures must be specified.

Eligibility Determinations

Eligibility determinations must be made by individuals who are employed under merit system principles by the State or local governments, including local health departments. These employees must refer any applicant who may be eligible for either Medicaid or CHIP to the State or local government social services office for an eligibility determination. Any individual eligible for either Medicaid or CHIP is not eligible for enrollment into the MCE or HCCI program.

DHCS will make eligibility determinations for those individuals who are eligible only for inpatient hospital services for a MCE program pursuant to W&I Code Section 14053.7 and Section 5072 of the Penal Code. DHCS will notify the appropriate LIHP of the eligibility determinations. These individuals determined eligible by DHCS must be

enrolled in the MCE program until eligible for disenrollment. The LIHP will be reimbursed the TFEs incurred for inpatient services for these MCE enrollees.

The applicant may choose to include in their MCE program those individuals determined eligible by the county and covered under W&I Code Section 14053.7(e). The county will provide the non-federal share for any adults eligible for these inpatient services who are determined eligible by the County.

Redeterminations

Eligibility redeterminations for MCE or HCCI enrollees must be conducted at least once every 12 months. These eligibility redeterminations can not be more restrictive during the redetermination period than those "in effect" during the period of the MCE or HCCI recipient's initial eligibility determination. Each redetermination must include a reassessment of the enrollee's eligibility for Medicaid and CHIP. If upon a redetermination, an enrollee is determined ineligible, he or she shall be disenrolled and referred to the County Medi-Cal Office. A MCE or HCCI enrollee may apply for eligibility under Medicaid or CHIP at any time for any reason.

Income Standards

Subject to available annual local funding, authorized applicants may reduce the highest allowable family income level and set a new upper income limit specific to the authorized applicant, if it determines that it is unable to enroll all eligible applicants within the family income levels at or below 133 percent of the FPL for MCE and/or above 133 through 200 percent of the FPL for HCCI. Authorized applicants may set upper income limits for the LIHP below the highest allowable income level for family income allowed in the MCE and HCCI programs. The MCE upper income limit can not be reduced below 133 percent of the FPL, if the authorized applicant is implementing the HCCI program. The authorized applicant may change the upper income limit prior to contract execution or at a later date. However, CMS must approve the proposed change to the upper income limit before it can be implemented. The applicant may set an upper income limit if they determine they are unable to enroll all eligible applicants within the family income levels at or below 133 percent of the FPL for MCE and above 133 through 200 percent of the FPL for HCCI.

MCE Enrollment Requirements

A HCCI program can not be implemented if a MCE program is not implemented or if the MCE upper income limit is below 133 percent of the FPL. Once the income limit is reduced below 133 percent the eligibility for HCCI program is no longer extended and new applicants can not continue to be enrolled in HCCI. Existing enrollees may continue to receive services and expenditures are claimable.

If an authorized applicant is implementing both MCE and HCCI programs, it must ensure that MCE applicants are enrolled into the MCE program before HCCI applicants are enrolled into the HCCI program. This means that in cases where continual

enrollment may exceed the funding available, MCE applicants must be given priority and enrollment caps may be established for the HCCI program. After the HCCI program is totally closed to new enrollment, an enrollment cap may be established for the MCE program. No FFP will be available for counties that enroll new HCCI applicants at the exclusion of MCE applicants.

Waiting Lists

Authorized applicants may implement waiting lists when an enrollment cap has been established. Local outreach must be provided to individuals on a waiting list for at least 6 months and individuals must be provided with the opportunity to sign up for other programs if they are still seeking coverage.

Due Process

The LIHP will establish hearing and appeals procedures as agreed to and required by the CMS and the DHCS pursuant to paragraph 76 of the STCs. By May 1, 2011 standards and procedures for hearings and appeals must be implemented which will include notices, requirement to maintain and reinstate services, hearing rights, and hearing decisions. The protocol will be a unique hearing process that includes Title XIX and 42 Code of Federal Regulations Section 438.

Program Requirements

The LIHPs will comply with program requirements, standards, and performance measurements pursuant to W&I Code Section 15909 *et seq.* and other applicable requirements, as set forth in the STCs of the Demonstration.

The LIHP will be effective upon implementation. Before the LIHP can be implemented the approved applicant must be in compliance with all LIHP requirements, be authorized by DHCS to implement the LIHP, and have executed a contract with DHCS for the LIHP under the Demonstration. For applicants with existing HCCI enrollees claiming can be effective back to November 1, 2010.

Health Care and Mental Health Services

The LIHP is required to provide the minimum core set of health care services listed in paragraph 63 of the STCs. Authorized applicants must also provide a minimum evidence-based benefits package for mental health services in accordance with paragraphs 64 and 65 of the STCs. Additionally, authorized applicants can provide other add-on health or mental health services allowable under Section 1905(a) of the Social Security Act as approved by CMS. Other add-on services may include substance abuse services. Authorized applicants may opt to provide mental health services through a delivery system that is separate from the LIHP.

MCE core set of health care services to the extent available under the California State Plan are:

- Medical equipment and supplies;
- Emergency Care Services (including transportation);
- Acute Inpatient Hospital Services;
- Laboratory Services;
- Mental health benefits as described below under MCE minimum mental health benefits ;
- Prior-authorized Non-Emergency Medical Transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available);
- Outpatient Hospital Services;
- Physical Therapy;
- Physician services (including specialty care);
- Podiatry;
- Prescription and limited non-prescription medications;
- Prosthetic and orthotic appliances and devices; and
- Radiology.

HCCI core set of health care services are:

- Medical equipment and supplies;
- Emergency Care Services;
- Acute Inpatient Hospital Services;
- Laboratory Services;
- Outpatient Hospital Services;
- Physical Therapy;
- Physician services;
- Prescription and limited non-prescription medications;
- Prosthetic and orthotic appliances and devices; and
- Radiology.

MCE minimum evidence-based mental health benefits are:

- Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
- Psychiatric pharmaceuticals.
- Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan will optionally expand the service(s).

Authorized applicants must cover emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the LIHP provider network.

Medical Home

Each enrollee will be assigned to a medical home in accordance with W&I Code Section 15910.2(b)(2). At a minimum the medical home shall provide a primary health care contact; an intake assessment; care coordination, care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and LIHP; use of clinical guidelines and other evidence-based medicine when applicable, focus on continuous improvement in quality of care; timely access to qualified health care interpretation as needed and as appropriate; and health information, education, and support in a culturally competent manner.

Cost Sharing Requirements

The LIHP must comply with the Medicaid cost-sharing requirements for State Plan populations for MCE and HCCI populations as required by paragraph 70 of the STCs. All LIHP enrollees must be limited to a 5 percent aggregate cost sharing limit per family. The counties with existing HCCI programs must be in compliance with all Medicaid cost-sharing requirements for State plan populations that are set forth in statute, regulations and policies by July 1, 2011.

Below is a Cost Sharing Quick Reference Chart

Income Population	***Premium or Enrollment Fee***	***Cost Sharing (except drugs)***	***Prescription Drug Cost Sharing***	***Aggregate Limit (monthly or quarterly)***
Individuals with family income at or below 100% of poverty	Not permitted	Cannot exceed nominal amount listed below	Both preferred and non-preferred drugs: Cannot exceed nominal amount listed below	5%
Individuals with family income exceeding 100% but not exceeding 150% of poverty	Not permitted	Cannot exceed 10% of the payment made for service (except for nonemergency services in ER: cannot exceed 2X nominal)	Both preferred and non-preferred drugs: Cannot exceed nominal amount listed below	5%

Income Population	*Premium or Enrollment Fee*	*Cost Sharing (except drugs)*	*Prescription Drug Cost Sharing*	*Aggregate Limit (monthly or quarterly)*
Individuals with family income exceeding 150% of poverty	Permitted (but applied to aggregate limit)	Cannot exceed 20% of the payment made for service (except for nonemergency services in ER: cannot exceed 2X nominal)*	Preferred: Cannot exceed nominal amounts listed below Non-preferred: Cannot exceed 20% of the State payment made for drug	5% (including any premium or enrollment fee imposed)

*Per CMS rule correction in 7.6.2010 federal register, and pending any subsequent clarification.

Payment for Service/Item	**Nominal Cost Sharing Amounts (FFY 2009 – subject to annual adjustment)**
$10.00 or less	$.60
$10.01 to $25.00	$1.15
$25.01 to $50.00	$2.30
$50.01 or more	$3.40

Utilization Management System Requirements

Authorized applicants must have procedures that include, but are not limited to, pre-authorization, concurrent review, retrospective review; a list of services requiring prior authorization and the utilization review criteria; utilization review appeals process for providers and enrollees; timeframes for medical authorization; and procedures to detect both under- and over-utilization of health care services.

Data Requirements

The LIHP will comply with DHCS requests for data. In addition to regular reporting to DHCS, LIHP counties will be required to submit data to an independent evaluator contracted by DHCS. Possible evaluation areas include efforts by LIHP programs to: (1) improve access to care and integration of care, including medical home and behavioral health services; (2) improve the health status of enrollees; (3) expand and improve coordination of care in the LIHP provider network; (4) develop efficient and integrated methods for transitioning the enrolled LIHP population into Medi-Cal in 2014; (5) reduce duplication of services; and, (6) achieve cost savings. All authorized applicants in LIHP will be required to meet minimum data capacity and reporting guidelines, and will need to be able to securely transfer Protected Health Information

(PHI) or sufficiently de-identified person-level health information to the evaluator via secure file transfer protocol (SFTP) connection on at least a quarterly basis. It will be necessary to execute Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreements (BAA) or other data use agreements with the evaluator to allow sharing of PHI or other information determined to be confidential in nature.

The independent evaluator will issue specific guidelines for dataset formatting and contents, which authorized applicants must respond to in order to establish standard datasets across all authorized applicants. All datasets provided by an authorized applicant must be linkable via shared unique identifiers. Authorized applicants must provide comprehensive data documentation and technical support for the use of all datasets by the evaluator. The following data sets will be required of authorized applicants:

- Enrollment data, including dates of application, enrollment, and disenrollment for all enrollment periods (data must be captured monthly);
- Demographic data for all enrollees;
- Data on all medical home assignments and changes within each LIHP system; and
- Complete list of medical homes, facilities and other types of providers, including practice locations, to evaluate adequacy of provider networks as well as access to care (requires unique provider identification (ID) variable).
- Claims or encounter data for all services provided under LIHP, including all procedure and diagnosis codes, specialty referrals, pharmaceutical National Drug Codes (NDC), linkable by unique ID at the person level;

Patient satisfaction data; anonymous or linkable by unique ID at the person level is also likely to be required.

Provider Network Delivery System

A county based delivery system with a closed network of providers is considered a managed care delivery system. Authorized applicants must comply with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to LIHP enrollees, and must ensure that all network providers are appropriately credentialed for the services provided. Authorized applicants must develop a network that is adequate to provide minimum core set of health care and mental health services.

Primary health care services are provided at a location within 60 minutes or 30 miles from each enrollee's place of residence. Primary care appointments are made available

within 30 business days of request during the period of the Demonstration term through June 30, 2012, and will be made available 20 business days during the Demonstration term from July 1, 2012, through December 31, 2013. Urgent primary care appointments will be provided within 48 hours (or 96 hours if prior authorization is required) of request.

Specialty care access will be provided at a minimum within 30 business days of request.

Network providers must offer office hours at least equal to those offered to the applicant's commercial line of business enrollees or Medicaid fee-for-service participants. Services are available 24 hours per day, seven days per week when medically necessary.

DHCS will establish alternative primary and specialty access standards for rural areas, service areas within a county with a population of 500,000 or fewer, other areas within a county that are sparsely populated, or other circumstances in which the standards are unreasonably restrictive.

In an area of Los Angeles County where an uneven distribution of population resides across a large geographic area, the county shall, in instances where there is no network participation by other designated public hospitals or non-designated public hospitals, include coverage of inpatient hospital services at the nearest network hospital through the provision of appropriate transportation that is commensurate with patient need, is required for obtaining medical care and is provided at the lowest cost mode available.

The LIHP must contract with or otherwise offer services through at least one federally-qualified health center (FQHC) and pay for these services for all FQHCs an amount at least equal to the amount the FQHC(s) would receive under the prospective payment system (PPS) rate.

Out-of-Network Emergency Services

In accordance with paragraph 63.f. of the STCs, the LIHP covers emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care for the MCE population, regardless of whether the provider that furnishes the services is within the LIHP network.

The LIHP pays for emergency services and post-stabilization services provided by out-of-network providers at 30 percent of the applicable regulatory fee-for-service rate under the State plan (less any supplemental payments), except that, with respect to inpatient hospital services, the LIHP pays 30 percent of the applicable regional un-weighted average of per diem rates paid to Selective Provider Contracting Program (SPCP) - contracted hospitals.

Payment is made only if the out-of-network provider notifies the LIHP program within 24 hours of admitting the patient into the emergency room, and, with respect to post-stabilization care, the out-of-network provider must meet the approval protocols established by the LIHP program.

Application Approval and Program Authorization

Approval Process

DHCS shall approve any application from an applicant that agrees to meet the following requirements set forth in W&I Code, Section 15910.2, 14053.7, Penal Code Section 5072, and STCs:

- Voluntarily agrees to commit to provide the non-federal share of LIHP expenditures for services to eligible adults.

- Agrees to provide inpatient hospital services, limited to only those services which are subject to FFP pursuant to Title XIX of the federal Social Security Act, to the individuals who are eligible for and enrolled in a county MCE program pursuant to W&I Code Section 14053.7 and Section 5072 of the Penal Code.

- Agrees to reimburse DHCS for the non-federal share of state staffing or administrative costs directly attributable to the cost of administering that authorized applicant's LIHP.

- Commits to active engagement and cooperative participation in the State transition plan activities beginning July 1, 2013. These transition activities will ensure a seamless enrollment process of LIHP enrollees into Medi-Cal, the Health Benefits Exchange or the Healthy Families program, as appropriate, beginning January 2014.

- Assigns eligible enrollees to a medical home. Each enrollee will be assigned to a medical home in accordance with W&I Code Section 15910.2(b)(2).

- Provides or contracts to provide the minimum core set of health care and mental health services.

- Develops a provider network to serve the eligible enrollees.

- Develops an outreach and enrollment plan.

- Develops a quality measurement and quality monitoring system.

- Develops data tracking systems.

- Develops a utilization management system.

- Provides consumer assistance to individuals applying for, participating in, or accessing, services in the LHIP.

- Agrees to comply with requirements, standards, and performance measurements developed by DHCS in consultation with authorized applicants.

DHCS will approve or deny applications within 60 calendar days of receipt date of the application. DHCS will approve those applications within this timeframe that include the required information. DHCS may deny any application that does not include the information required for application approval, or if at any time an applicant becomes nonresponsive. If an application is denied, DHCS will send a written notification to the applicant and specify the reason for the denial. Within 10 calendar days from the receipt date of the written notification of application denial, the applicant may submit a request for reconsideration of the application denial to DHCS. DHCS will provide written response to applicants' requests for reconsideration of application denials within 20 calendar days from the receipt date of the requests that confirms or reverses the denial, and specifies the reasons for the decision. Applicants that are denied participation in the LIHP may submit an application in the subsequent application process.

Application approval only signifies that the applicant may participate in the LIHP. An approved applicant may not implement LIHP until authorized by DHCS and the DHCS contract between DHCS and the authorized applicant has been executed.

LIHP Authorization Process

The next step after application approval is the authorization process. DHCS will provide additional instructions and request information needed to complete the authorization process for approved applicants. DHCS will collaborate with approved applicants to identify information necessary to demonstrate compliance with the LIHP requirements of the Demonstration and W&I Code, Sections 14053.7 and 15909 - 15915, and Penal Code Section 5072, including but not limited to, the following:

- Provider network requirements, which include network adequacy and access requirements, out-of-network emergency services for medically necessary emergency care services for LIHP enrollees, and inclusion of at least one FQHC in the provider network and payment for these services. The FQHC payment amount for all FQHCs is at least equal to the amount the FQHC(s) would receive under the prospective payment system (PPS) rate.

- Enrollment requirements, which include: MCE applicants are enrolled prior to HCCI applicants, standardized enrollment procedures, and the use of enrollment caps and waiting lists in the program.

- Eligibility requirements, which include Medicaid cost sharing requirements, Medicaid standardized eligibility procedures, income rules for eligibility determinations, and upper income limits.

- Due process standards and procedures, for grievances, fair hearings, and appeals pursuant CMS approved standards and procedures.

- Provision of the nonfederal share of LIHP expenditures for services to eligible adults.

- Provision of inpatient hospital services, limited to only those services which are subject to funding with federal financial participation pursuant to Title XIX of the federal Social Security Act, to the special population who are eligible for and enrolled in a county MCE program pursuant to W&I Code Section 14053.7 and Section 5072 of the Penal Code.

- Reimbursement to DHCS of the non-federal share of DHCS staffing or administrative costs directly attributable to the cost of administering that county or counties' LIHP.

- Assignment of eligible individuals to a medical home in accordance with W&I Code Section 15910.2(b)(2).

- Program requirements, which include the minimum core set of health care and mental health services, outreach and enrollment plan, quality measurement and quality monitoring system, data tracking systems, utilization management system, and consumer assistance to individuals applying for, participating in, or accessing, services in the LHIP.

The information needed to support compliance with LIHP requirements must be provided to DHCS according to the LIHP Implementation Timeline if the program(s) are to be implemented no later than June 30, 2011.

Implementation, Contracting, and Application Details

Implementation and Contract

Once authorized by DHCS to implement their MCE and/or HCCI program(s) and the contract with DHCS has been executed, the LIHP may be implemented. Each authorized applicant will be required to enter into a contract with DHCS prior to program implementation and being reimbursed for expenditures for health care and mental health services and allowable administrative activities provided under the LIHP. The

contract will include, but not be limited to, specific details of the LIHP and reimbursement of expenditures to authorized applicants. Application information may be revised or changed during the contract process. However, CMS may need to approve certain changes.

This application, including any part of the process described in this document for approving applicants' LIHP and determining the HCCI allocations, and any agreements entered into with a county, a city and county, a consortium of counties, or a health authority, is not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code (Welfare & Institutions Code (W&I Code) § 15907, subdivision (e).

Requirements, processes, and procedures set forth in the application do not constitute incorporation or affirmation of either the provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation. Likewise, use of certain provisions and terminology in the application is for administrative convenience only and does not, by that use, constitute adoption or incorporation of any provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation.

Application

All materials submitted in response to this application will become the property of DHCS and become subject to the Public Records Act (Government Code Section 6250 et seq.) once program authorizations and HCCI allocation notices are issued. Therefore, DHCS requests that applicants do not submit any information with the application that it considers confidential or proprietary.

Application contents, applicant correspondence, application review working papers and any other part of the application process will be held in the strictest confidence until the program authorizations and HCCI allocation notices are issued.

All processes and procedures set forth in this application constitute the sole administrative processes and procedures available for applicants in the February 14, 2011 application process. No further administrative remedies (e.g., protests, appeals, or requests for reconsideration) will be available for applicants following DHCS' issuance of its written response to LIHP applicants' request for reconsideration. Eligible applicants may submit an application in subsequent application periods as announced by DHCS.

The applicable state statute and the STCs of the Demonstration are incorporated by reference into this document.

Application Submission Requirements

Each applicant must:

1. Complete the application according to the instructions. Certain information as specified in the application, may be submitted to DHCS at a later date specified by the application. Estimated and projected information can be revised at any time during the application process and/or the contract process.

2. Seek written clarification of application requirements or instructions from DHCS.

3. Submit the application electronically to the LIHP mailbox at LIHP@dhcs.ca.gov according to the following format:

    - A Microsoft word document or PDF. A rich text format can also be used.

    - Do not include any graphics or pictures except the map for Attachment 5, Alternative Access Standards. Do not send encrypted or as a secure e-mail.

    - Include a scanned electronic copy of the signed signature page.

4. Sign the hard copy signature page in blue ink. The application must be signed by an individual with authority to submit the application on behalf of the applicant.

5. Ensure applications are e-mailed or postmarked no later than February 14, 2011, or hand delivered to DHCS by 5:00 p.m. PST on February 14, 2011.

6. Each applicant submitting the application by hard copy must arrange for timely delivery of the application to one of the addresses specified below. Submit hard copy applications using one of the following options:

Hand Delivery or Overnight Express	**U.S. Mail**
Low Income Health Program Application Bob Baxter Dept. of Health Care Services Safety Net Financing Division, MS 4519 1501 Capitol Avenue Sacramento, CA 95814-5005	**Low Income Health Program Application** Bob Baxter Dept. of Health Care Services Safety Net Financing Division, MS 4519 P.O. Box 997436 Sacramento, CA 95899-7436

If the hand delivery option is chosen, please allow adequate time to locate parking and to wait at the security desk on the street level until a DHCS staff member accepts the application. Upon arrival in the building, inform the security personnel that you have a delivery for Mr. Bob Baxter, at telephone number: (916) 552-9597.

Applicants are responsible for all costs of developing and submitting an application. These costs cannot be charged to DHCS or be included in any cost reimbursement process for the LIHP.

Application Withdrawal and Resubmission

An applicant may withdraw an application at any time before the submission deadline by submitting a written withdrawal request signed by the applicant's authorized representative. All withdrawal requests must be submitted using one of the submission and delivery options specified above. DHCS requests that applicants confirm with Ms. Leanne O'Dell at (916) 650-0199 that the withdrawal request was received.

An applicant, who withdraws an application during the application process, may resubmit a new application according to the application submission instructions. Resubmitted applications must be received no later than February 14, 2011, by 5:00 p.m. PST using one of the delivery options specified or in subsequent application periods after the end of the first application period.

Please visit the LIHP website at http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx, or through the LIHP button on the left side of the the DHCS home page at www.dhcs.ca.gov, to stay informed of any subsequent information to assist in the development of the application.